SECTION 12 - PATIENT CARE PRACTICES

I. HANDWASHING.

A. GENERAL.

Handwashing is the single most important factor in the prevention of infection and the control of cross-infection between personnel and patients. All personnel providing direct patient or having any physical contact with patients or their equipment will practice frequent handwashing.

B. SPECIFIC.

1. **Routine Handwashing**: Handwashing using a liquid soap, lasting 10-15 seconds performed on a routine basis including, but not limited to the following times.

a. Whenever hands are visibly soiled

b. Prior to and after eating

c. Between patient contacts.

d. After using the bathroom facilities.

e. After blowing the nose

f. Prior to and after each emptying of urinary drainage bags or collecting patient specimens.

2. Invasive Procedure preparation: A 30 second handwashing using an iodophor or chlorhexidine, including the fingers, between the fingers, hands, wrists to mid forearm. This is to be performed prior to and after the following invasive procedures and at the indicated times:

a. Before beginning work.

b. At the completion of work.

c. Catheterization or catheter irrigation.

d. Tracheostomy care

e. IV therapy and invasive line insertion.

f. Dressing changes/wound irrigations.

3. **Operating Room Preparation**: A minimum of 3 minute scrub using an iodophor or chlorexidine, including the fingers, between the fingers, under the fingernails, hands, wrists to mid forearm.

C. HANDWASHING PROCEDURE:

1. It is preferable to wash hands under warm running water using soap from a dispenser.

2. Bar soap will not be used.

3. Healthcare lotion soap should be used for routine handwashing and chlorhexidine 2% Dyna-Hex or 4%CHG; iodophor (Betadine Scrub) in preparation for a procedure.

4. Wet hands and apply a sufficient amount of soap to obtain a good lather (five cc's for lotion soap). The briefest acceptable duration of handwashing is 10-15 seconds, but one half minute is preferred.

5. Be careful to wash fingernails and between fingers.

6. Rinse thoroughly and dry hands with individual paper towels.

7. Use dry paper towel to turn off faucet.

8. It is important to keep hands clean and pliable. Chapped or rough skin is difficult to keep free of contamination. Do not use hand creams from a jar. Latex compatible lotion is provided in all clinical areas for staff use.

D. USING A WATERLESS HAND CLEANER:

1. A waterless hand cleaner i.e., Calstat provides a rapid kill of transient flora foundon the hands of healthcare workers. It may be used in the absence of gross or visible contaminants on the hands, i.e., blood or body fluids.

2. Use between patients on doctor's rounds.

3. Before entering and after exiting an isolation room.

4. Alcohol-based hand rinses contain emollients to reduce hand dryness.

II. Personal Protective Equipment (PPE) - will be provided for employees at risk for exposure to blood and body fluids. The supervisor will ensure that PPE is utilized appropriately by all staff.

A. Gloves

1. Gloves will be worn when contact with mucous membranes, non-intact skin,

blood, blood products, or any body fluids is anticipated. The wearing of gloves does not negate the need for handwashing. When gloves are worn, bacteria rapidly multiply on gloved hands and there is danger of perforation. A pair of gloves MUST be donned just before starting a task or procedure and removed immediately when the task or procedure is completed.

2. Gloves must be worn during phlebotomy and when performing any vascular access procedure.

3. Sterile gloves will be used for invasive procedures and open wound care.

4. Non-sterile latex gloves will be used for contact with potentially infective materials and patient care procedures. Vinyl gloves are not recommended as they fail more often than latex. Non-latex gloves are available for staff with documented sensitivity to latex.

5. Single use disposable gloves will be discarded when visibly soiled, between patient contact, when torn, punctured or when their ability to function as a barrier is compromised. Single use disposable gloves will not be washed or disinfected for reuse as this may cause them to fail and allows migration of organisms to the skin.

6. Gloves of a thicker material (utility gloves) will be used when cleaning with a disinfectant. Utility gloves may be disinfected for reuse, if the integrity of the glove is not compromised, otherwise they must be discarded.

7. Double gloving may reduce tactile sensation and dexterity. However, this practice is recommended when performing an autopsy or when large amounts of blood are present.

B. Masks, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.

C. Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

D. Surgical caps or hoods and shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, surgery).

E. Maintenance of PPE

1. If a garment(s) is penetrated by blood or other potentially infectious material, the garment(s) will be removed immediately or as soon as possible. Notify linen control and they will make arrangements to launder and return the employee's soiled garments. Clothing or uniforms soiled with blood are not to be taken home by the employee for

cleaning.

2. All PPE will be removed prior to leaving the work area or as soon as possible after overt contamination.

3. PPE WILL NOT BE TAKEN FROM THE WORK SITE.

4. Disposable PPE will be discarded when visibly contaminated. Reusable aprons may be washed with an approved disinfectant when visibly soiled. Aprons will be discarded when they become torn or unserviceable.

5. Eye protection, face shields, and shoes which become contaminated will be washed with an approved disinfectant and allowed to air dry.

6. Hospital supplied lab coats and uniforms requiring cleaning will be placed in the soiled linen bag and sent for laundering.

7. Issuance, receipt, and replacement of PPE will be coordinated by the NCOIC.

III. ASEPTIC TECHNIQUE.

A. GENERAL. Asepsis is the absence of disease-producing organisms. Aseptic techniques are those practice which help reduce the transmission of pathogenic organisms from one person or place to another. Aseptic techniques are necessary to prevent contamination of wounds, to isolate the site to be worked on from the rest of the body, to create a sterile field for sterile procedures, and to protect staff, patients and visitors from needless risk of exposure to infection.

B. SPECIFIC.

1. Keep the patient's area clean and separate from other patients and their personal articles.

2. Keep all contaminated material away from the patients and one's own body. Wash hands after contact.

3. Wash hands prior to any contact with sterile items.

4. Put on sterile gloves, gowns and masks as required by the procedure.

5. Sterile equipment should be handled only with sterile gloves or other sterile equipment.

6. Establish a sterile field when doing procedures (e.g., spinal taps, suturing lacerations, dressing changes, wound irrigations) which require asepsis. All trays and sets should have an inner wrappers, sterile towel of drapes which can be used for this purpose; if not use disposable sterile drapes.

7. Prepare the sterile field immediate before use and keep it in view at all times; an unattended sterile field and long exposure to air increases the potential for contamination.

8. Keep sterile items separated from non-sterile items. Establish an area away from the sterile field for waste.

9. Remember when opening sterile wrap items that both wrappers are opened. The inside package must not be touched by an unsterile object; if this occurs the sterile object is contaminated.

10. The edges of the inside wrappers of sterile supplies are not sterile once a package has been opened. Only the top of the sterile field is considered sterile.

11. DO NOT reach across the sterile field and never pass an unsterile item across a sterile field.

12. Keep the sterile area dry. Moisture will contaminate the field.

13. Avoid excessive movement around a sterile field. Stay at least one foot away from a sterile field.

14. If there is any doubt as to the sterility of an item, DO NOT USE it. The following are reasons to reject an item:

a.. IT has fallen on the floor (even if it is in the original packaging unless plastic covered.

b. It is, or shows signs of having been, wet or is damp/wet.

c. There are holes, tears or breaks in the wrapper, or the seal on the packaging permits outside air into the package.

d. The sterilization expiration date has passed. Always check the expiration date on any sterile item before using it.

e. The external sterilizing tape or the internal indicator have not changed to the appropriate color.

IV. URINARY CATHETERIZATION AND CARE.

A. GENERAL

Catheter associated urinary tract infections account for 41% of all nosocomial infections. This policy reviews the Infection Control concerns related to the maintenance of indwelling urinary catheter systems and for obtaining specimens from those systems. Reference nursing SOP for the procedure for foley catheter insertion and irrigation technique. Urinary catheters should be inserted only when needed and left in place only as long as

necessary. A physician will determine the need for catheterization in most cases. When a catheter is to remain in the patient, a closed drainage system will be used and maintained at all times.

B. SPECIFIC.

1. Appropriate handwashing will be performed before and after any manipulation of the catheter site or apparatus.

2. Indwelling foley catheters are supplied with a urometer to prevent opening the closed system to attach a drainage bag. Maintaining a closed drainage system is a crucial part in the prevention of nosocomial device-related urinary tract infections. The closed urinary drainage system should not be broken unless there is a physician order to irrigate the bladder. Irrigation is accomplished using aseptic technique.

3. Always secure the catheter to the hypogastrium area or the inner thigh to prevent meatal trauma.

4. Catheter care using povidone-iodine solutions and ointments have not resulted in decreased urinary tract infections. TWICE DAILY cleaning of the perineal area around the catheter with mild soap and water should be done. This may be done as patient self-care if they are able.

5. The catheter and tubing should not be changed unless there is encrustation in the tubing that inhibits urine flow. If there is a need for change, the entire system should be changed. Drainage bags need not be replaced unless leakage, blockage, soil or the integrity of the system has been compromised.

6. A non-obstructed downward flow of urine must be maintained. This is achieved through completing the following actions:

a. Keep the catheter and collection tubing free of kinks.

b. Always maintain the catheter drainage system below bladder level to prevent reflux into the patient's bladder.

c. The collection bag should be emptied regularly using a separate collecting container for each patient. The drainage spigot and non-sterile collecting container should never come in contact.

7. Obtaining Urine Specimens from Catheterized Patients

a. Urine for culture should not be obtained from the drainage bag. Catheter tips will not be cultured

b. Gather required equipment: alcohol swab, a 5-10 cc syringe, a small gauge (22 or 23 g) needle, and a sterile specimen container

c. Swab the port on the drainage tubing with alcohol for one full minute.

d. Insert a small gauge needle into the aspirating port at a 45 degree angle.

e. Aspirate 5-10 cc of urine. If no urine is in the tubing, pinch the tubing and wait until the urine is visible before aspirating.

f.. Place aspirated urine in a sterile container, label correctly and transport to the lab within 30 minutes.